

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: <u>00-19-HA</u>	2. STATE: New Jersey
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX	
4. PROPOSED EFFECTIVE DATE July 22, 2000		

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(13)(A) of the Social Security Act, 42 CFR 447, Subpart C; 447.253.271	7. FEDERAL BUDGET IMPACT: a. FFY 2000 \$ 5.1 million b. FFY 2001 \$19.5 million
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19A Page 158.2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): New Page

**SEE REMARKS

10. SUBJECT OF AMENDMENT:
Additional Payments for Nominal Charge Hospitals

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☒ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Exempt pursuant to 7.4 of the Plan
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Division of Medical Assistance and Health Services P.O. Box 712 Trenton, NJ 08625-0712
13. TYPED NAME: Michele K. Guhl	
14. TITLE: Commissioner	
15. DATE SUBMITTED:	

7. DND

8. REMARKS:
Attachment 4.19A page 158.2 has been reviewed and the original submitted page with the same number. Also, the page number is incorrect on 158.

11.1 Additional Payment for Nominal Charge Hospitals

- a) Any New Jersey acute care hospital that has been recognized by the New Jersey Medicaid program as a nominal charge hospital for three prior years, and which has had a Medicaid fee-for-service utilization greater than 30 percent in its first finalized cost report for the hospital's fiscal year ending during 1995, shall be eligible to receive enhanced payments for providing inpatient services to New Jersey Medicaid and New Jersey FamilyCare-Plan A fee-for-service beneficiaries.
- b) Effective for services rendered after July 21, 2000, interim payments shall be made in equal lump sum amounts according to a monthly schedule, based on an estimate of the total enhanced amount payable to a qualifying hospital, subject to cost settlement.
- c) Final enhanced payments shall be determined at cost settlement, and shall be calculated as follows: \$2,150 per Medicaid inpatient day, adjusted by a volume variance factor (the ratio of expected Medicaid inpatient days to actual Medicaid inpatient days for the rate year) and subject to a pro rata adjustment so that the total enhanced per diem amounts are equivalent to the total annual State and Federal funds appropriated in the amount of \$52 million.

00-19-MA(NJ)

New Page

TN 00-19 Approval Date JUN 06 2001
Supersedes TN New Effective Date 7/22/00